As with the first option, some opponents argue that current health insurance coverage is not excessive. Opponents of the tax credit argue that the tax system should not be used to encourage purchases of certain goods or services and that extending the credit to those who currently have no employer-paid health insurance would further this tendency.

The Administration's tax reform proposal would include in taxable income the first $10 per month (for single coverage) or $60 per month (for family coverage); H.R. 3838 would retain the current law exclusion for health insurance benefits.

ENT-02 REDUCE MEDICARE'S PAYMENTS FOR INDIRECT MEDICAL EDUCATION COSTS

Savings from CBO Baseline	Annual Savings (millions of dollars) 1987	1988	1989	1990	1991	Cumulative Five-Year Savings
Outlays	780	1,000	1,100	1,250	1,350	5,480

Medicare's prospective payment system (PPS) includes higher payment rates to cover the additional costs of patient care (that is, costs of treating each Medicare patient) incurred by hospitals with teaching programs. These costs are known as indirect medical education costs. The federal portion of payments for hospitals with approved medical education programs are raised by 11.59 percent for each 0.1 percentage point of the hospital's ratio of full-time equivalent interns and residents to its number of beds (IRB). This addition is double the adjustment estimated at the onset of PPS by the Health Care Financing Administration (HCFA) as necessary to compensate for indirect medical education costs. The Congress doubled the adjustment as an interim step to cover higher costs caused by a variety of factors that were not otherwise accounted for in setting PPS rates. These factors include severity of illness (within diagnosis-related groups), inner-city location, and a disproportionately large share of low-income patients--all of which are associated with large teaching programs.

Further analysis of the indirect teaching adjustment by CBO, using a statistical method that allowed the adjustment to reflect all factors not now considered in setting PPS rates, found the adjustment factor to be 8.7 percent--about 25 percent lower than the current adjustment of 11.59 percent. Moreover, the analysis demonstrated that indirect costs of medical education increase at a slower rate as teaching programs get larger. Therefore, the current method of making equal incremental payments for each 0.1 percentage-point increase in the IRB (a linear basis) tends to overcompensate hospitals with the largest teaching programs. If the current adjustment were reduced to 8.7 percent and restructured in a manner consistent with CBO's analysis to pay smaller increments as the teaching programs get larger (a curvilinear basis), indirect teaching payments would be reduced by $5.5 billion over fiscal years 1987-1991.

Although this proposal would reduce total revenues for hospitals, it would better align their PPS payments with the patterns of costs the system

was designed to recognize. Problems of equity would continue to arise, however, using the indirect medical adjustment to pay for factors other than teaching costs. For example, all teaching hospitals would receive these payments, although many are not located in inner cities or do not serve a disproportionately large share of low-income patients. Moreover, a number of nonteaching hospitals have these characteristics, but would continue to receive no additional payments.

The Administration has proposed that the indirect teaching adjustment be reduced to 5.795 percent and be paid on a curvilinear basis. This proposal would save approximately $9.8 billion over fiscal years 1987-1991, but would no longer compensate teaching hospitals for costs associated with severity of illness and scope of facilities.

ENT-03 REDUCE REIMBURSEMENTS FOR CAPITAL EXPENDITURES UNDER MEDICARE

Savings from CBO Baseline	Annual Savings (millions of dollars) 1987	1988	1989	1990	1991	Cumulative Five-Year Savings
Move Immediately to a Prospective Reimbursement System						
Outlays	220	450	700	960	1,270	3,600
Move Immediately to a Prospective Reimbursement System and Redefine Capital Expenses						
Outlays	490	790	1,120	1,420	1,780	5,600
Move Slowly to a Prospective Reimbursement System and Redefine Capital Expenses						
Outlays	20	100	370	800	1,310	2,600

Although the Social Security Amendments of 1983 set up a prospective payment system (PPS) to reimburse hospitals for operating costs associated with treating Medicare beneficiaries in various diagnosis-related groups (DRGs), they did not change the retrospective, cost-based method of reimbursing capital-related expenses such as interest, rent, and depreciation. Reimbursements for capital expenses account for about 9 percent of Medicare payments to hospitals--roughly $4 billion in fiscal year 1986.

All three of the approaches discussed here would lead to prospective payment of capital. The first two would do so immediately, while the third would partially retain cost-based reimbursement during a five-year transition to a fully prospective system. In addition, two of the approaches would redefine the capital expenses that would be eligible for reimbursement under the prospective system.

Move Immediately to a Prospective Reimbursement System. The current cost-based method of reimbursement for capital-related expenses could be replaced immediately by a prospective system under which capital expenses would be reimbursed by increasing all the DRG rates by the same fixed

percentage. If this percentage add-on were set at the ratio of capital costs to operating costs in 1986, Medicare's outlays would be reduced by $3.6 billion during the fiscal year 1987-1991 period. These savings would accrue because the DRG payments are projected to grow more slowly than actual capital costs.

Reimbursing capital expenses through the DRG rates would have several advantages. First, hospitals would have incentives to reduce capital costs as well as operating costs--for example, by seeking to delay projects when interest rates were high, whereas now that is not advantageous because all interest costs are reimbursed. In addition, this approach would avoid the current incentive to substitute capital for labor--the incentive that comes from combining prospective reimbursement for operating costs with cost reimbursement for capital expenses--even when that would raise the hospital's total costs. Finally, capital payments by Medicare would be predictable and controllable--for example, these outlays would not be increased if a hospital building boom occurred in the coming years.

The major drawback to this approach stems from the fact that individual hospitals' capital expenditures tend to be large and to occur infrequently, so some hospitals have capital expenses that are much higher than average in some years and much lower in other years. In other words, a percentage add-on based on the ratio of national capital costs to national operating costs in a base year would generally not match any particular hospital's current expenses.

A partial solution would be to have a transition period during which part of the prospective payment would be based on the national percentage add-on described above and part would be based on the particular hospital's capital-to-operating cost ratio in the base year. This modification--which is similar to the transition used under the PPS system for operating costs--would still move to a prospective system immediately and would not affect the total savings. The distribution of payments among hospitals during the transition period would differ, however. Hospitals that have recently undertaken large capital obligations would gain, relative to using only a national percentage add-on, while hospitals that currently have below-average capital expenses but need to modernize in the near future would be disadvantaged.

Move Immediately to a Prospective Reimbursement System and Redefine Capital Expenses. In addition to paying for capital prospectively, as in the previous option, the definition of capital expenses used to calculate the percentage add-on could be changed in two ways. First, Medicare could exclude the proportion of capital costs related to return-on-equity (ROE),

which is currently an allowable cost only for proprietary hospitals. Proponents argue that the federal government ought to reimburse all hospitals in the same way--whether they are voluntary or proprietary. Moreover, because proprietary hospitals receive only about 10 percent of Medicare's payments, they point out that including ROE in the base for calculating the percentage add-on would spread these payments across all hospitals, effectively generating windfall gains for the voluntary ones. But others contend exactly the opposite--that ROE is a legitimate cost of doing business and either should continue to be reimbursed based on actual costs or should be paid prospectively under a separate add-on that would apply only to proprietary hospitals.

A second definitional change would reduce the amount of interest expenses used to calculate the fixed percentage add-on by the amount of interest hospitals earn on funded depreciation. Advocates of this offset point out that hospitals have invested their funded depreciation to generate income rather than using it to reduce the level of their outstanding debt, and they argue that the federal government should not reward hospitals for the resulting increase in their interest expenses. Opponents contend, on the other hand, that the prospective payments for operating costs are already low and that further cuts in federal payments would add to the financial stress some hospitals are experiencing from the PPS.

This option would lower Medicare's outlays by $5.6 billion during the 1987-1991 period. These savings would accrue both because the redefinition would lower the 1986 base amount of capital expenses by $320 million, and because under the prospective system for capital--which shares the advantages and disadvantages discussed in the previous option--payments are projected to grow more slowly than actual capital costs.

Move Slowly to a Prospective Reimbursement System and Redefine Capital Expenses. Another approach would be to move gradually from the current cost-based system to a prospective one in which capital expenses were redefined. For example, if during a five-year transition, 95 percent, 80 percent, 60 percent, 40 percent, and 20 percent, respectively, of the reimbursement were based on capital costs as now defined, with the remainder based on the prospective system described in the second option, cumulative savings for fiscal years 1987-1991 would be $2.6 billion.

Advocates of this approach argue that continuing partial cost-based reimbursement during a transition period would lessen financial stress for two large groups of hospitals--those with current high capital costs and those planning large capital investments during the transition period--and would reduce windfall gains for many others whose actual costs would be

below Medicare's payments under the prospective system. Opponents counter that this approach would substantially reduce budgetary savings compared with immediate implementation of the prospective system and that the positive incentives of paying prospectively would be delayed.

The Administration's budgetary proposal contains aspects of the approaches detailed above. It would redefine allowable capital expenses over a three-year period and, over four years, would move to paying for capital expenses through a fixed percentage add-on to the DRG rates. During the transition, the hospital-specific portion would not necessarily be set prospectively; instead, it would be the lower of the hospital's actual capital costs or its 1986 costs increased by the growth in a typical hospital's capital costs since then.

ENT-04 REDUCE MEDICARE'S PAYMENTS TO HOSPITALS FOR DIRECT MEDICAL EDUCATION EXPENSES

Savings from CBO Baseline	Annual Savings (millions of dollars) 1987	1988	1989	1990	1991	Cumulative Five-Year Savings
Outlays	100	190	270	350	440	1,350

Medicare's prospective payment system does not include payments to hospitals for their direct costs of graduate medical education (GME)--that is, residents' and teachers' salaries, administrative costs, and classroom expenses. Instead, these costs are reimbursed separately and retrospectively, based on the proportion of total inpatient days attributable to Medicare beneficiaries. Last year, through regulation, the Administration imposed a one-year freeze on these payments by establishing a ceiling on the total reasonable costs of GME for each hospital. The Congress could continue to freeze GME payments from 1987 through 1991, but on a per-resident basis in order to allow hospitals flexibility to vary the sizes of their programs. The five-year savings would be about $1.3 billion. (This option would not change the treatment of training programs for nursing and allied health professions.)

Several arguments support limiting Medicare's payments for GME, which are currently nearly one-third of institutions' total GME costs. For example, such reductions would parallel the recent treatment of other federal programs that subsidize medical education, which have been cut back because of an expected surplus of physicians and because of budgetary constraints. In addition, by reimbursing whatever reasonable costs are incurred the current system encourages growth in the direct costs of residency programs; freezing payments on a per-resident basis would lower--and might even reverse--this incentive.

A long-term freeze on the GME passthrough would have several drawbacks, however. First, a per-resident GME funding freeze might adversely affect the quality of training provided by hospitals. Second, a per-resident freeze would not address concerns about the oversupply of some medical specialists and the undersupply of others. Third, fewer patient care dollars for low revenue-producing residency programs--such as family practice--might make some of these programs financially unviable. Fourth, because hospitals' cost accounting practices vary in the share of actual GME costs

currently reported, a freeze would prevent improvements in cost accounting from being reflected in more accurate payments. Finally, an extended freeze might eventually leave payment rates below the costs of patient care that is now provided by residents. In this instance, other payers might be forced to subsidize care for Medicare patients or the quality of those patients' care might deteriorate, because other Medicare payments to hospitals do not cover these costs.

Several alternatives to a freeze would address some of these drawbacks. For example, to respond to concerns about oversupply of various specialties, the Congress might limit GME reimbursements to the costs of residents in particular specialties or in the early years of their training programs. Programs not reimbursed under this approach, however, might be unable to find alternative sources of funding and might be forced to close. Another alternative would be to calculate the per-resident payments for groups of hospitals, thereby reducing the effect of individual accounting practices on payment levels. Such an approach, however, would not recognize the actual cost of the programs to the hospitals, so some programs would be reimbursed for less than their costs and others would receive more.

The Administration's 1987 budget would eliminate Medicare payments for the education- and classroom-related costs of residency programs. In addition, hospital-specific limits on payments for residents' services would be set.

ENT-05 INCREASE THE HOSPITAL INSURANCE PAYROLL TAX

	Annual Added Revenues (billions of dollars)					Cumulative Five-Year
	1987	1988	1989	1990	1991	Addition
Addition to CBO Baseline	7.4	10.2	10.9	11.8	12.8	53.1

The Hospital Insurance (HI) component of Medicare, which accounts for almost 70 percent of total program outlays, is largely financed by a portion of the Social Security payroll tax. Employees covered by the HI program and their employers currently each contribute 1.45 percent of the first $42,000 of earnings. The taxable earnings ceiling rises automatically with average wages each year.

Increasing the HI payroll tax rate would reduce the federal budget deficit and help maintain the solvency of the HI trust fund. Although projections for the trust fund are uncertain, financial problems are ultimately likely to occur because HI outlays are projected to grow faster than income, in part because of the aging of the population. A 0.5 percentage-point increase in the combined tax rate for employers and employees beginning in 1987, for example, would generate $53 billion in revenues over the 1987-1991 period and postpone any future financing problems.

Some argue, however, that payroll taxes are already too high. Currently scheduled increases mean that the combined employer and employee Social Security tax rate--for retirement benefits, disability payments, and Medicare--will have increased by 3.6 percentage points between 1975 and 1990, from 11.7 percent to 15.3 percent. Moreover, Social Security payroll taxes already account for an increasing share of total federal revenues--rising from 26 percent in 1980 to about 34 percent in 1989. Further increases in the payroll tax could have adverse effects on employment and inflation, because the cost of hiring workers would rise. In addition, this option would increase both the relative and absolute tax burden of those with lower earnings, because the tax applies only to earnings below a specified limit.

The Administration did not propose any changes in the HI payroll tax.

ENT-06 ADOPT A FEE SCHEDULE FOR REIMBURSING PHYSICIANS UNDER MEDICARE

Savings from CBO Baseline	Annual Savings (millions of dollars) 1987	1988	1989	1990	1991	Cumulative Five-Year Savings
Fee Schedule with Rates Updated Annually by the MEI						
Budget Authority	--	150	270	370	500	1,290
Outlays	--	130	250	340	460	1,180
Fee Schedule with Spending Cap Set by the MEI						
Budget Authority	--	720	1,500	2,440	3,590	8,250
Outlays	--	570	1,310	2,200	3,240	7,320
Fee Schedule with Spending Cap Set by Growth in GNP						
Budget Authority	--	160	300	480	760	1,700
Outlays	--	130	260	430	670	1,490

Medicare currently reimburses physicians under the Supplementary Medical Insurance (SMI) program for "reasonable" charges for all covered services. A reasonable charge for a given service is the lowest of the physician's actual charge, the physician's customary charge for that service, and the prevailing charge for that service in the local community. This is known as the customary, prevailing, and reasonable (CPR) system.

Because of the automatic and inflationary link between physicians' actual charges and Medicare's payment rates in the next year, the CPR system has been criticized for contributing unnecessarily to cost increases. To weaken this link, since 1973, the allowed rate of increase in prevailing fees has been limited to the rate of increase in an economywide index of office expenses and earnings--the Medicare Economic Index (MEI). Because not all physicians' customary fees are at the ceiling set by prevailing fees, however, the rate of increase in payment rates has exceeded increases in the MEI. (Based on CBO tabulations from the Part B Medicare Annual Data Provider file, about 55 percent of reasonable charges were at the ceiling in 1984.)

As an alternative to the CPR system, a Medicare fee schedule--with adjustment for local differences in costs--could perhaps be put in place by October 1, 1987. The fee schedule that would be effective for fiscal year 1988 could be set at the average amounts allowed for each service during the previous year, with annual increases in payment rates determined thereafter by the rate of increase in the MEI. Savings under this option would be $130 million for fiscal year 1988, and would total $1.2 billion over the five-year period 1987-1991. 1/

One problem with this option is that a fee schedule based on average allowed amounts would incorporate elements of the current fee structure that many people believe need to be corrected, such as excessive payments for certain procedures that are either ineffective or far less costly to perform now than when they were first introduced. The rate structure could be modified incrementally after it has been put in place, or changes in physician payment methods could be delayed for several years until a more appropriate fee structure was developed. (The Health Care Financing Administration has awarded a contract to develop a relative value scale that could serve as the basis for a fee schedule; completion is scheduled for mid-1988.)

Further, control of total costs in a fee-for-service payment system probably requires constraints on volume of services as well as on fees. Other countries have successfully contained increases in volume under such systems by using two mechanisms in combination: volume-related adjustments in payment rates to cap total spending for physicians' services, together with a systematic monitoring of the practice profiles of physicians to prevent individual ones from making above-average increases in their billings at the expense of other physicians. If increases in total approved charges per enrollee were capped by increases in the MEI--so that payment rates would be reduced to offset increases in volume per enrollee--savings under the fee schedule discussed above would increase to $570 million for 1988 and would total $7.3 billion over the five-year period.

Some increases in volume of services per enrollee might be desirable, however, to account for aging of the Medicare population and medical advances. Total charges per enrollee could be permitted to increase by the growth in costs plus an appropriate allowance for these factors, before triggering a downward adjustment in payment rates. The appropriate allowances for aging and technology could be difficult to determine, however. This is especially so for medical advances, which might either increase or reduce the variety and costs of services that could benefit enrollees.

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1. See CBO, *Physician Reimbursement Under Medicare: Options for Change* (forthcoming).

One option would be to allow total charges per enrollee to increase each year according to growth in GNP. Consequently, some increase in the volume of services per enrollee would be permitted so long as payment rates increased less rapidly than GNP. Savings under this option would be $130 million for 1988 and $1.5 billion over the five-year projection period, but the allowed growth in volume could be greater or less than that warranted by aging and technological change.

Other approaches could reduce the undesirable incentives for volume by basing reimbursements on more comprehensive packages of services--such as all services provided during an episode of hospital inpatient care (similar to the prospective payment system for hospital reimbursement), or on all services required by enrollees during a specified period of time (capitation). Before either of these alternatives could become the dominant payment method for physicians' services under Medicare, however, a number of implementation and feasibility issues would need to be resolved. Implementation of a fee schedule now would not prevent more fundamental changes in payment methods later, when acceptable alternative approaches are developed.

The Administration has proposed to retain the CPR system for the time being, with some refinements, while taking steps to increase the number of Medicare enrollees receiving care on a capitated basis in the long term. The principal refinements to the CPR system the Administration plans include: making a technical correction to the MEI that would have the effect of reducing the increase in MEI-adjusted prevailing fees scheduled for October 1, 1986, from an estimated 3.2 percent to only 0.8 percent; reducing payment rates for selected services that seem to be overpriced; and encouraging carriers to reduce the number of locality and specialty differentials they recognize.

ENT-07 INCREASE MEDICARE'S PREMIUM FOR PHYSICIANS' SERVICES

Savings from CBO Baseline	Annual Savings (millions of dollars) 1987	1988	1989	1990	1991	Cumulative Five-Year Savings
Budget Authority	970	1,350	1,430	1,525	1,620	6,895
Outlays	970	1,350	1,430	1,525	1,620	6,895

Medicare's Supplementary Medical Insurance (SMI) program is partially funded by monthly premiums--currently $15.50--paid by enrollees. Between 1972 and 1982, premium receipts covered a declining share of SMI costs--dropping from 50 percent to 25 percent--because premiums were tied to the rate of growth in Social Security benefits, which is based on the Consumer Price Index, rather than on the faster-rising per capita cost of SMI. (The remaining costs are paid from general revenues.)

In 1982, premiums were set through 1985 (later extended through 1987) to cover 25 percent of the average benefits for an aged enrollee. Under current law, beginning in 1988 the premium calculation will again be limited to the rate of growth of Social Security benefits. If, instead, the premium were set so that participants would pay 30 percent of benefits beginning January 1, 1987, and for all years thereafter, federal savings would total $1.0 billion in fiscal year 1987 and $6.9 billion over the five-year period. The estimated premium would be $21.70 on January 1, 1987, instead of the scheduled $18.10.

Under this option, the increase in payments would be shared by all enrollees, in contrast to increased copayments that would affect only the users of medical services, who may be more financially pressed during their period of illness. Also, it would not affect the poorest enrollees because they are likely to be eligible for Medicaid, which usually pays the SMI premium on their behalf. For those not eligible for Medicaid, the higher premium would be less than 5 percent of the average monthly Social Security benefit in 1987, slightly more of a burden than in 1967--the first full year for Medicare--when the premium was 3.6 percent of the average Social Security benefit.

Low-income enrollees who are not eligible for Medicaid could find the increased premium burdensome, though. A few might drop SMI coverage and either do without care or turn to sources of free or reduced-cost care, which could increase demands on local governments.

In its 1987 budget, the Administration proposed to increase the SMI premium gradually over five years, until it would cover 35 percent of costs. This would save more over the five-year period, but less in the first two years, than the option discussed here.

ENT-08 USE THE TAX SYSTEM TO IMPOSE A SUPPLEMENTARY INCOME-RELATED PREMIUM FOR PHYSICIANS' SERVICES

	Annual Added Revenues (billions of dollars)					Cumulative Five-Year Addition
	1987	1988	1989	1990	1991	
Addition to CBO Baseline	0.5	1.9	2.0	2.1	2.3	8.8

Part B of Medicare offers Supplementary Medical Insurance (SMI), which covers a portion of enrollees' physician and other nonhospital charges. Participation is voluntary, and enrollees currently pay a monthly premium of $15.50. The premium is adjusted annually to cover 25 percent of the average costs incurred by an elderly enrollee. The balance of costs, more than $20 billion for 1987, is paid from general revenues.

An alternative to increasing the share of costs financed by the current premium would be to impose a supplementary income-related premium. To avoid having to set up a new bureaucracy to collect these premiums from enrollees, this option could be most conveniently introduced through the income tax system.

A 1 percent tax, for example, could be imposed on enrollees' taxable income above the zero bracket amount. A ceiling on added tax liability for each tax filing unit (usually an elderly individual or couple) could be set by the number of SMI enrollees in the unit times the average value of subsidized SMI benefits per enrollee. In this way, no unit would pay more than the full actuarial value of its benefits. If an SMI tax of 1 percent were imposed on taxable income for all units with at least one SMI enrollee during the tax year (prorated for part-year enrollment), revenues earmarked for the SMI trust fund would be increased by $0.5 billion in 1987, and by $8.8 billion over the five-year period. 1/

In contrast to the premium discussed in ENT-07, this approach would fall less heavily on low-income enrollees and more heavily on those with

1. See CBO, *An Analysis of Selected Deficit Reduction Options Affecting the Elderly and Disabled* (March 1985).

high incomes. The poorest enrollees--those with no taxable income--would not be affected, whether or not they were eligible for Medicaid benefits. The amount paid would vary directly with the amount of taxable income. As a result, individuals with taxable income below $6,890 a year would pay less under this approach, while those with taxable income above $6,890 would pay more than if premiums were increased to cover 30 percent of costs. The effect on low- and moderate-income enrollees could be reduced still further by using personal income tax rates--as in ENT-09--rather than the proportional tax used in this option.

Some people might consider the tax inequitable because the amount of tax paid by each tax unit would not vary with the number of SMI enrollees in a unit, except for a small number of high-income tax units affected by the ceiling. In addition, some might question whether it was fair to require those with higher incomes to pay a relatively greater share of SMI costs when such people are typically less costly to the Medicare program because of their better health.

The Administration has made no proposal for an income-related SMI premium.

ENT-09 TAX A PORTION OF MEDICARE BENEFITS

Addition to CBO Baseline	Annual Added Revenues (billions of dollars) 1987	1988	1989	1990	1991	Cumulative Five-Year Addition
With Income Threshold	0.8	2.9	3.5	4.3	5.3	16.8
Without Income Threshold	1.5	5.1	6.0	7.0	8.2	27.8

Eligibility for Hospital Insurance (HI) benefits is based on working-year tax contributions, half of which are paid by employees from after-tax income and half by employers from pre-tax income. Eligibility for Supplementary Medical Insurance (SMI) depends on payment of a premium, which currently covers about 25 percent of SMI benefits. Hence, effective January 1, 1987, 50 percent of the insurance value of HI benefits and 75 percent of the insurance value of SMI benefits might be treated as taxable income for enrollees, with the resulting tax proceeds returned to the Medicare trust funds. This proposal is analogous to taxing part of Social Security benefits, which is already part of the law for beneficiaries for whom modified adjusted gross income plus half of Social Security benefits exceeds $25,000 (for individuals) or $32,000 (for couples).

If the current income thresholds for the tax on Social Security benefits were also used to limit the application of the tax on Medicare benefits--with the portion of Medicare benefits described above added to modified adjusted gross income plus half of Social Security benefits to compare with the threshold--then taxing both HI and SMI benefits would yield additional revenues of $0.8 billion in 1987 and $16.8 billion over the five-year period 1987-1991. If no income thresholds were used to limit the application of the Medicare tax, additional revenues would be $1.5 billion in 1987 and $27.8 billion over the five-year period. 1/

A tax on HI benefits would strengthen the HI trust fund. A tax on SMI benefits would shift some SMI costs from the general taxpayer to enrollees,

1. See CBO, *An Analysis of Selected Deficit Reduction Options Affecting the Elderly and Disabled* (March 1985).

without increasing costs for low-income enrollees and therefore not threatening their access to care. Moreover, if income thresholds were used, even middle-income enrollees would be protected from additional liability under this option. (Higher-income enrollees would pay more under this option than under ENT-08, but only because of the inclusion of HI as well as SMI costs. In contrast to ENT-08, people enrolled in the SMI program would never pay the full insurance value of their benefits under this option, since the maximum personal income tax rate to be applied to the subsidy value of benefits would be 50 percent under current law.) Further, since this option would use the mechanism already in place for taxing Social Security benefits, it would present no additional administrative difficulty.

Unlike the tax on Social Security benefits, though, this tax would be imposed on the insurance value of in-kind benefits rather than on dollar benefits actually received--a modification of current tax policy. (If the tax were imposed on actual benefits received, however, the Medicare tax would be directly related to enrollees' health care costs, reducing the insurance protection Medicare is intended to provide.) In addition, some people object to this option because enrollees could not alter their tax liability by choosing a different package of benefits, except by dropping SMI coverage altogether. Further, because of their better health, people with higher incomes are typically less costly to the Medicare program. Thus, requiring them to pay a greater share of the costs might be viewed as inequitable. Finally, the additional tax liability could be substantial--up to $800 per enrollee for 1987.

The Administration has made no proposal to tax Medicare benefits.